SECTION 2
ADA 2000 CLAIM FILING INSTRUCTIONS

The ADA-2000 claim form should be typed or legibly printed by hand or electronically. It may be duplicated if the copy is legible. Medicaid paper claims should be mailed to:

Infocrossing Healthcare Services, Inc.
P.O. Box 5300
Jefferson City, MO 65102

Information about ordering claim forms and provider labels is in Section 3 of the Medicaid *Providers Manual* available at www.dss.mo.gov/dms.

NOTE: An asterisk (*) beside a field number indicates a required field. These fields must be completed or the claim is denied. All other fields should be completed as applicable. Two asterisks (**) beside the field number indicates a field is required in specific situations.

Field number and name		Instructions for completion
1-7		Not required.
8.*	Patient Name	Enter the patient's last name first, first name, and middle initial as shown on the patient's Medicaid card.
9.	Address	Not required.
10.	City	Not required.
11.	State	Not required.
12.	Date of Birth	Not required.
13*.	Patient ID#	Enter the Medicaid ID number as shown on the patient's Missouri Medicaid card.
14.	Sex	Not required.
15.	Phone Number	Not required.
16.	Zip Code	Not required.
17-18		Not required.

19-30**		When verifying the patient's eligibility, verify if there is other insurance coverage. If applicable, enter the name of the dental insurance, their address, and the policy number. If the other insurance pays, the amount paid should be entered in field 59, section "Payment By Other Plan". **LEAVE BLANK IF THERE IS NO OTHER DENTAL COVERAGE.** (These fields should reflect only non-Medicaid information.)
31-37**	Other Insurance	Required only if patient has a second dental policy. **LEAVE BLANK IF THERE IS NO OTHER DENTAL COVERAGE.** (This field should reflect only non-Medicaid information.)
38-41		Not required.
42.*	Name of Billing Dentist or Dental Entity	Write or type the provider's name exactly as it appears on the label.
43.	Phone Number	Not required.
44.*	Provider ID#	Write or type the provider's Missouri Medicaid number exactly as it appears on the provider label.
45.	Dentist SSN or TIN	Not required.
46.	Address	Not required.
47.	Dentist License #	Not required.
48.	First Visit Date	Not required.
49.	Place of Treatment	Not required.
50.	City	Not required.
51.	State	Not required.
52.	Zip Code	Not required.

FIELDS 42, 46, 50, 51, AND 52 MAY BE COMPLETED WITH THE USE OF THE MISSOURI MEDICAID PROVIDER LABEL.

53.**	Radiographs	Mark "yes" if x-rays accompany the claim. ***Do not*** send x-rays routinely, the State Dental Consultant will request them if needed. Refer to the Dental manual for specific procedures which require x-rays.

54-55.	Not required.
56.* Is Treatment a Result Of…	If treatment is the result of an occupational illness or injury, mark “yes” and list the date, location and cause, otherwise, mark “no”.
57.* Is Treatment a Result Of...	Mark the appropriate box. If marked “yes”, enter date and location.
58. Diagnosis Code Index	Not required.
59.* Date of Service	Enter the actual date services were rendered in month/day/year numeric format. **REMINDER: The date of service for dentures (full or partial) is the date of placement.**
* Tooth Number or Letter	Enter the appropriate tooth number or letter for services performed on each line item of the claim. If a particular tooth number or letter does not apply, leave blank. When billing for partial dentures enter the tooth number for one of the teeth being replaced in this field, then list the remaining teeth in the description field. A – T Deciduous teeth 1 – 32 Permanent teeth AS – TS Deciduous supernumerary tooth 51 – 82 Permanent supernumerary tooth Alveoplasties should be billed using tooth number 1 for upper right quadrant, 9 for upper left quadrant, 17 for lower left quadrant, and 25 for lower right quadrant.
* Surface Code	Complete this field, **if applicable.** M – Mesial D – Distal O – Occlusal L – Lingual I – Incisal F – Facial B - Buccal
Diagnosis Index #	Not required.

* Procedure Code	Enter the five digit code for the service performed, as well as any applicable modifiers.
* Quantity	The quantity will always be one (1) except for some injection codes.
** Description	Only required in specific situations as indicated in the Dental Manual.
* Fee	Enter your usual and customary fee for the procedure(s) performed.
* Total Fee	Enter the total of the charges shown.
**Payment by Other Plan	Enter the total amount received by all other insurance resources. Previous Medicaid payments, and cost-sharing, co-insurance, or copay amounts are not to be entered in this field. If the other insurance denied the claim, attach a copy of the Explanation of Benefits which denied the charges.
* Admin. Use Only	You may enter the recipient's patient account number in this field.
Maximum Allowable	Not required.
Deductible	Not required.
Carrier %	Not required.
Carrier Paid	Not required.
Patient Pays	Not required.
60. Identify the missing teeth...	Not required.
61.** Remarks	For timely filing purposes, if the claim is resubmitted after the date of service is one year old, enter the Internal Control Number (ICN) of the previous related claim, or attach a copy of the original remittance advice indicating the claim was initially submitted within one year from the date of service.
62-66	Not required.

Dental Claim Form

MISSOURI MEDICAID PROGRAM

1. ☐Dentist's pre-treatment estimate ☐Dentist's statement of actual services Specialty (see backside)
2. ☐Medicaid Claim ☐EPSDT Prior Authorization #
3. Carrier Name
4. Carrier Address
5. City | 6. State | 7. Zip

PATIENT

8. Patient Name (Last, First, Middle) | 9. Address | 10. City | 11. State
12. Date of Birth (MM/DD/YYYY) / / | 13. Patient ID # | 14. Sex ☐M ☐F | 15. Phone Number ( ) | 16. Zip Code
17. Relationship to Subscriber/Employee: ☐Self ☐Spouse ☐Child ☐Other
18. Employer/School Name Address

SUBSCRIBER / EMPLOYEE

19. Subs./Emp. ID#/SSN# | 20. Employer Name | 21. Group #
22. Subscriber/Employee Name (Last, First, Middle)
23. Address | 24. Phone Number ( )
25. City | 26. State | 27. Zip Code
28. Date of Birth (MM/DD/YYYY) / / | 29. Marital Status ☐Married ☐Single ☐Other | 30. Sex ☐M ☐F

39. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

X
Signed (Patient/Guardian) Date (MM/DD/YYYY)

OTHER POLICIES

31. Is Patient covered by another plan ☐No (Skip 32–37) ☐Yes: ☐Dental or ☐ Medical | 32. Policy #
33. Other Subscriber's Name
34. Date of Birth (MM/DD/YYYY) / / | 35. Sex ☐M ☐F | 36. Plan/Program Name
37. Employer/School Name Address

38. Subscriber/Employee Status ☐Employed ☐Part-time Status ☐Full-time Student ☐Part-time Student
40. Employer/School Name Address
41. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

X
Signed (Employee/subscriber) Date (MM/DD/YYYY)

BILLING DENTIST

42. Name of Billing Dentist or Dental Entity | 43. Phone Number ( ) | 44. Provider ID # | 45. Dentist Soc. Sec. or T.I.N.
46. Address | 47. Dentist License # | 48. First visit date of current series: | 49. Place of treatment ☐Office ☐Hosp. ☐ECF ☐Other
50. City | 51. State | 52. Zip Code | 53. Radiographs or models enclosed? ☐Yes, How many?_____ ☐No | 54. Is treatment for orthodontics? ☐Yes ☐No If service already commenced: Date appliances placed Total mos. of treatment remaining
55. If prosthesis (crown, bridge, dentures), is this initial placement? ☐Yes ☐No If no, reason for replacement: Date of prior placement:
56. Is treatment result of occupational illness or injury? ☐No ☐ Yes Brief description and dates
57. Is treatment result of: ☐auto accident? ☐other accident? ☐neither Brief description and dates

58. Diagnosis Code Index (optional) 1. 2. 3. 4. 5. 6. 7. 8.

59. Examination and treatment plans – List teeth in order

Date (MM/DD/YYYY)	Tooth	Surface	Diagnosis Index #	Procedure Code	Qty	Description	Fee	Admin. Use Only

60. Identify all missing teeth with "X"

Permanent																Primary										
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

Total Fee	
Payment by other plan	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

61. Remarks for unusual services

62. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

X
Signed (Treating Dentist) License # Date (MM/DD/YYYY)

63. Address where treatment was performed
64. City | 65. State | 66. Zip Code

GTE DATA SERVICES COPY

RETURN ORIGINAL TO:
GTE DATA SERVICES
P.O. BOX 5300
JEFFERSON CITY, MO 65102